KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illness

The Kansas Mental Health Coalition is comprised primarily of statewide organizations representing consumers of mental health services, families of consumers, community service providers and dedicated individuals as well as community mental health centers, hospitals, nurses, physicians, psychologists and social workers.

The Kansas Mental Health Coalition is an Organization Dedicated to Improving the Lives of Kansans with Mental Illnesses and Severe Emotional Disorders. KMHC is a coalition of consumer and family advocacy groups, provider associations, direct services providers, pharmaceutical companies and others, all of whom share this common mission. Within the format of monthly roundtable meetings, participants forge a consensus agenda which provides the basis for legislative advocacy efforts each year. This design enables many groups otherwise unable to participate in the policy making process to have a voice in public policy matters that directly affect the lives of their constituencies. The result of this consensus building is greater success for our common goals. Our current membership includes 51 non-profit organizations, 5 for profit, and numerous individuals which get together once a month to discuss issues of common concern and develop consensus.

Concerns relating to Implementation of a Preferred Drug List for Medicaid Mental Health Prescriptions Presented to Kansas Health Policy Authority Board

The Kansas Mental Health Coalition respectfully submits its concerns relating to the potential implementation of mental health management procedures for mental health medications prescribed to Kansans receiving Medicaid benefits.

We appreciate the efforts by Executive Director Marci Nielsen and Medicaid Director Andy Allison to share information about their proposal and to engage in discussion about our concerns. We recognize that the Board has already taken action to approve amending the Kansas statutes to permit medication management.

KMHC supports goals of the agency to pursue enhanced safety for Medicaid recipients and to find cost savings within the system wherever possible. Unfortunately, our members fear that the proposal to remove protections in Kansas statutes which promise that Medicaid recipients will get the medications their physicians prescribe is a drastic measure that may threaten the safety and health of the people the proposal is designed to help.

Kansas statute 39-7,121b states that "no requirements for prior authorization or other restrictions on medications used to treat mental illnesses such as schizophrenia, depression or bipolar disorder may beimposed on Medicaid recipients." Members of the Kansas Mental Health Coalition worked to obtain this language during the 2002 Legislative Session. We consider this exemption from cost-motivated restricted formularies to be important language and will need to be convinced to remove such important language from Kansas law.

Mental health medications are crucial to the recovery of Kansans who are fighting mental illness. Finding appropriate prescriptions and dosage is not simple. Many times, an individual must attempt numerous combinations of medications or dosages in order to find a successful treatment regimen. Any effort to restrict access to medications represents the potential for setbacks for those who have found successful treatment and dangerous delays for those who are only beginning their treatment.

Important considerations have already been discussed with the agency:

- Recommending equivalent medications only when those medications are EXACTLY equivalent
- Grandfathering all individuals who are currently on prescribed medications
- Creating a drug utilization review committee consisting of mental health professionals to make recommendations to the current DUR committee

Further, the agency has also suggested that they would not begin any PA system without the implementation of an electronic automated PA system – for which no funding was authorized by the 2008 Legislature. There is an automated system from EDS that may be put into place – but, as yet, we do not know how well such a system will work. It will not

contain the "bells and whistles" of a premium system. Certainly, the use of an automated system must provide whatever elements are necessary to insure that a medical professional can get the appropriate medications to their patients – without the delays that can lead to harm for that patient.

Please recognize that the Kansas Mental Health Coalition was actively involved in meetings with the Kansas Health Policy Authority about amending the MediKan program and is working with the agency to move forward with a possible PDL for that program. This effort is barely in its beginning stages. We would do well to move forward with that process before jumping into a PDL for the entire Medicaid program.

The majority of MediKan beneficiaries have a psychiatric diagnosis. Less than 25% of this vulnerable population will ultimately qualify for Medicaid benefits – therefore, the temporary assistance provided by MediKan provides important access to health care and prescription medications. Although the program is more limited than Medicaid, it is a significant connector to public mental health services. Psychotherapeutic medications make up a large percentage of the overall pharmacy expenditures for the program. This is a difficult population to serve, with many of the recipients lacking family support, medical records or even a permanent address.

Representatives of the Kansas Mental Health Coalition have met with KHPA leadership to identify potential policy changes that may result in some savings for the program. These items are still pending.

Although safety is mentioned as a primary goal for this implementation, we are concerned that the agency has not fully explored other options available for aiding providers in appropriate prescribing patterns. These efforts should be pursued before changing the statutes. Are we looking at an appropriate tool to provide safety? Or is it simply a supporting element to legitimize what is truly a budget initiative? It is the budget motivation that will make this a difficult issue during the upcoming legislation session.

We have a great deal of information provided to our organization indicating that exempting mental health drugs from restrictions is advisable. Numerous studies point to the potential problems with preferred formularies. See attached.

- A Harvard Medical School study published online in April 2008 by Health Affairs uncovered a rash of troubling discontinuations from treatment among Maine Medicaid patients with schizophrenia after the state imposed prior authorization requirements on the use of some atypical antipsychotic drugs. Researchers found a pronounced risk of treatment discontinuity while the prior authorization policy was in effect. Of 151 discontinuities it identified in the Maine group it studied, 104 were gaps in therapy that lasted for more than 30 days. The researchers found no similar patterns of medication discontinuation when looking at the New Hampshire patient group that was not subject to any prior authorization restrictions. Moreover, according to researchers, costs savings under Maine's effort were modest, averaging $2.33 per patient per month. The author of the study, Stephen B. Soumerai, Professor of Ambulatory Care and Prevention at Harvard Medical School, said, "It is more difficult to place restrictions in the arena of chronic mental illness. The populations you're treating are highly vulnerable, and the various drugs work differently on different patients."

As long as studies point to such dangers, our organization will be unable to support the drastic choice of deleting the mental health medication exemption from the statutes. However, we stand ready to continue to communicate with the agency and to promote policies that can move us in a positive direction to promote safety and to find savings.

Our Coalition will work to collect data on this subject and to advise the Kansas Legislature to proceed very cautiously. Although I am only able to speak to the position of our membership today, I know that many organizations representing the disability community are paying close attention to this issue and may also have information to contribute.

For More Information, Contact:

Kansas Mental Health Coalition
c/o Amy A. Campbell, Lobbyist
P.O. Box 4103, Topeka, KS 66604
785-234-9702, cell: 785-969-1617; fx: 785-234-9718, kmhc@amycampbell.com

c/o Roy W. Menninger, MD, Chair
85 SW Pepper Tree Lane, Topeka, KS 66611-2072
785-266-6100, fx: 785-266-9004, roymenn@sbcglobal.net

Literature/Research Review on Impact of PDLs/PAs and DURs on Mental Health

- In an article titled, "Systemwide Effects of Medicaid Retrospective Drug Utilization Review Programs," published in the Journal of Health Politics, Policy and Law, August 2000, the study indicated that restricted formularies reduced drug expenditures per capita by 14.8 percent, but they had no significant effect on the number of prescriptions per recipient. According to their analysis, formularies have significant spillover effects within the Medicaid program. Per capita expenditures on inpatient mental hospital services and on physician services are 39.1 percent and 28.7 percent higher in formulary states than in nonformulary states. Because of these offsetting increases in expenditures, the authors reported that restricted formularies have no significant impact on total Medicaid expenditures per capita. The cost savings in the drug budget are offset by increased expenditures in other parts of the system. Aggregate pooled cross-sectional and time-series annual state data for 1985 to 1992 were used in this study.

- A study of Maine's experience with priority authorization by Harvard Medical School professor Stephen Sumerai (Health Affairs, April 2008) concluded that there was a 29% greater risk of treatment discontinuity (30 days without medication, switching of medication, or augmentation of medication) as a result of the prior authorization requirement. Because a switch in or augmentation of medication may also represent fine-tuning of therapy as well as discontinuity of treatment, the more useful finding is that there was an 18% greater risk of a patient going more than 30 days without medication as a result of the prior authorization policy change. Sumerai cites research b Gitlin (American Journal of Psychiatry, 2001) finding that 80% of schizophrenics suffer a relapse when they go off their medication. Because relapses are highly correlated with adverse outcomes (such as ER visits, hospitalizations, homelessness, violence resulting in incarceration, etc.), the finding of a greater likelihood of medication gaps as a result of prior authorization can reasonably be expected to have cost consequences outside the Medicaid pharmacy budget.

- The American Psychiatric Institute for Research and Education investigated the clinical impact of commonly used prescription drug utilization management policies in ten state Medicaid programs of policy interest using data from a large, national study conducted in 2006.

<u>Findings</u>

Medication Access Problems

- ✓ Overall, 40% of Medicaid patients were reported to have experienced a medication access problem in 2006.
- ✓ Rates of medication access problems varied considerably across the states, ranging from 27% to 65% of patients affected.
- ✓ States with the lowest rates of reported medication access problems were New York (27%), Texas (31%), and California (32%), while Tennessee (63%), Georgia (64%), and Michigan (65%) has the highest rates.

The most common medication access problems included:

- ➢ Patient's inability to obtain medication refills or new prescriptions because they were not covered or approved (34% of patients overall).

- Clinically indicated medications clinicians preferred to use were not able to be prescribed because of prescription drug coverage/approval issues or patient copays (29%).
- Discontinuing or temporarily stopping medication as a result of prescription drug coverage or administrative or management issues (26%).
- Patients having problems obtaining medications because of patient copays (14%).

Adverse Events

- All the medication access problems studied were strongly associated with increased adverse events, including ER visits, hospitalizations, incarcerations, or homelessness. Seventy-two (72) percent of patients with medication access problems had an adverse event compared to 49% of patients without access problems.
- Forty-two (42) percent of patients with medication access problems had an ER visit reported compared to 28% among patients with no access problems reported.
- Patients who discontinued/temporarily stopped medications as a result of prescription drug coverage or management had 4 times increased odds of an adverse event.

Prescription Drug Utilization Management Policies Associated with Access Problems and Adverse Events

- All the prescription drug utilization management policies studied were highly associated with increased rates of medication access problems. Fifty-seven (57) percent of patients reported to have a utilization management policy apply to their prescription drugs has a medication access problem compared to 14% among patients without prescription drug utilization management.
- Prior authorization was associated with 6 times higher odds of experiencing a medication access problem; use of preferred drug or formulary lists were associated with 5 times higher odds; and "step therapy" or "fail first" protocols were associated with 4 times higher odds.
- Each of the prescription rug utilization management policies studies was highly associated with increased rates of adverse events.

This study suggests state prescription drug policies may have a major impact on outcomes for mentally ill beneficiaries and highlights the need for more effective prescription drug management strategies and policies to promote medication continuity and more cost-effective treatment. Furthermore, this study indicates prescription drug utilization management strategies may have significant "cost offset" implications with medication access problems associated with greater health care services utilization and costs, as well as costs to the social services and criminal justice sectors.

- The American Psychiatric Institute for Research and Education studies the impact of Medicare Part D on medication access and continuity among the "dual eligible" patients with mental and addictive illnesses through a large, national study conducted in 2006. Primary findings:

  - More than half the dual eligible psychiatric patients studies had at least one problem with medication access or continuity since January 1, 2006. These patients were not able to access medication refills or new prescriptions or they discontinued or temporarily stopped their medications as a result of the changes in the coverage and management of prescription drug benefits.

- Significantly more patients with medication access problems experienced a significant adverse clinical event, such as an ER visit, hospitalization, homelessness, or detained/incarcerated in a jail or prison, compared to patients with no access problems (69% versus 40%).

- The APA Medicare Part D research (published in American Journal of Psychiatry, May 2007), found that nearly one in five psychiatric patients were switched to a different mental health medication because the clinically preferred medication was not covered or approved. The outcomes were serious: over one in three had an emergency room visit and over 15 % were hospitalized. Among patients who had medication access or continuity problems, 19.8% has a subsequent ER visit, and 11% had a hospitalization. An increase in suicidal ideation or behavior was reported for 21.7%, an increase in violent ideation or behavior occurred in 14.5% and 3.1% became homeless for more than 48 hours.

- A Harvard Medical School study published online in April 2008 by Health Affairs uncovered a rash of troubling discontinuations from treatment among Maine Medicaid patients with schizophrenia after the state imposed prior authorization requirements on the use of some atypical antipsychotic drugs. Researchers found a pronounced risk of treatment discontinuity while the prior authorization policy was in effect. Of 151 discontinuities it identified in the Maine group it studied, 104 were gaps in therapy that lasted for more than 30 days. The researchers found no similar patterns of medication discontinuation when looking at the New Hampshire patient group that was not subject to any prior authorization restrictions. Moreover, according to researchers, costs savings under Maine's effort were modest, averaging $2.33 per patient per month. The author of the study, Stephen B. Soumerai, Professor of Ambulatory Care and Prevention at Harvard Medical School, said, "It is more difficult to place restrictions in the arena of chronic mental illness. The populations you're treating are highly vulnerable, and the various drugs work differently on different patients."

- In an article titled, "Benefits and Risks of Increasing Restrictions on Access to Costly Drugs in Medicaid, published in the January/February 2004 issue of Health Affairs, the author (Stephen Soumerai, Professor of Ambulatory Care and Prevention at Harvard Medical School) states "For certain therapies (such as selective serotonin reuptake inhibitor, or SSRI, antidepressants), differences in chemical composition or pharmacologic properties of individual drugs in a class could result in poorer treatment response among recipients of preferred drugs." He goes on to say, "Acutely ill patients with unipolar depression, bipolar illness, or schizophrenia often do not respond to the first or second psychoactive medication regimen because of idiosyncratic differences between patients; it is often impossible to predict which drugs will ultimately be effective."

- According to The National Governor's Association Center for Best Practices, Issue Brief titled, "Preferred Drug Lists and Supplemental Rebates: Managing Care and Containing Costs," dated March 2003, "States generally exclude drugs for the treatment of mental health, cancer, and HIV from prior authorization."